

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIVIDUAL COMPLAINT FORM FOR EMPLOYMENT DISCRIMINATION
Based On
Race, Color, Religion, Sex, National Origin, Age, Disability,
or Retaliation

PLEASE NOTE: IF YOU HAVE NOT CONSULTED AN EEO COUNSELOR, GO TO THE
EEO STAFF OFFICE FOR THE ORGANIZATION WHERE YOU BELIEVE DISCRIMINATION
OCCURRED FOR ASSIGNMENT OF AN EEO COUNSELOR TO ADVISE YOU. INFORMAL PRE-
COMPLAINT EEO COUNSELING IS A REQUIREMENT AND NO FORMAL COMPLAINT CAN BE
ACCEPTED FOR INVESTIGATION WITHOUT IT.

PLEASE TYPE OR PRINT

1. _____
_____ Complainant's Name and Social
Security Number

2. _____
_____ Complainant's Representative

Home Address-Street, RD,

P.O. Box

Business Address

City State Zip Code

Home Phone: ()
Business Phone: ()
IF DIFFERENT, GIVE PHONE AND
AREA CODE WHERE YOU CAN BE
REACHED DURING NORMAL BUSINESS
HOURS.

City State Zip Code

Business Phone: ()
IF REPRESENTATIVE IS EMPLOYED IN
THE DEPARTMENT, STATE WHERE AND
GIVE PHONE NUMBER TO BE USED
DURING NORMAL WORKING HOURS.

3. IF YOU DO NOT WORK FOR THE
DEPARTMENT GIVE YOUR POSITION,
NAME OF EMPLOYING ORGANIZATION
AND LOCATION; IF YOU DO WORK
FOR THE DEPARTMENT, GIVE TITLE

4. IN WHAT ORGANIZATION, OFFICE OR
UNIT OF THE DEPARTMENT DO YOU
BELIEVE DISCRIMINATION/RETALIA-
TION AGAINST YOU OCCURRED? ALSO,
IF YOU KNOW, GIVE ITS
SERIES, GRADE, ORGANIZATION

ADMINISTRATIVE CODE
AN ITS ADMINISTRATIVE CODE

-
5. WHAT IS THE DATE YOU RECEIVED
THE Final EEO Counseling
ALLEGED
DISCRIMINATORY/RETALIATORY
EVENT OR
IN COUNSELING?

6. WHAT IS THE LAST OR MOST
RECENT DATE OF AN
Report.
INCIDENT COVERED

-
7. SHOW THE BASIS OR BASES ON WHICH YOU WERE DISCRIMINATED/RETALIATED
AGAINST FROM AMONG THE FOLLOWING BY INDICATING ONE APPROPRIATE
NUMBER
IN FIRST, SECOND OR THIRD SPACE. SECOND AND THIRD SPACES (BASES)
NOT NECESSARILY REQUIRED.

(1) AGE ____ YRS.; (2) COLOR; (3) MENTAL DISABILITY; (4) PHYSICAL
DISABILITY; (5) NATIONAL ORIGIN-HISPANIC; (6) NATIONAL ORIGIN-
OTHER;
(7) SEX-MALE; (8) SEX-FEMALE; (9) RACE-BLACK; (10) RACE-WHITE;
(11) RACE-OTHER; (12) RELIGION; (13) RETALIATION/REPRISAL.

FIRST BASIS ____ ; SECOND BASIS ____ ; THIRD BASIS ____

FOR AGE, YOU MUST HAVE BEEN AT LEAST 40 YEARS OLD WHEN THE MATTER
OF
CONCERN OCCURRED. PLEASE STATE IN YOUR COMPLAINT (ITEM 8, BELOW)
YOUR
COLOR, PHYSICAL OR MENTAL IMPAIRMENT, NATIONAL ORIGIN, SEX, RACE

OR

RELIGION ACCORDING TO THE BASIS OR BASES OF YOUR COMPLAINT.

-
8. STATE YOUR COMPLAINT. USE EXTRA SHEETS IF NECESSARY. IDENTIFY THE SPECIFIC ACTS, INCIDENTS OR EVENTS AND THE DATES ON WHICH THEY OCCURRED WHICH YOU BELIEVE WERE DISCRIMINATORY OR IN RETALIATION AGAINST YOU.

-
-
9. THE FOLLOWING REMEDIAL OR CORRECTIVE ACTION WILL RESOLVE MY COMPLAINT:

-
-
10. COMPLAINTS MUST BE SIGNED BY THE COMPLAINANT, AND DATED.

Complainant's Signature

Date

-

A LEGIBLE COPY OF THE FINAL EEO COUNSELING REPORT TOGETHER WITH A LEGIBLE COPY OF ALL ATTACHMENTS TO THE FINAL COUNSELING REPORT MUST BE FILED WITH THIS COMPLETED FORM, IF A COMPLAINANT CHOOSES TO USE THIS FORM.

